Electronically Delivered

February 15, 2023

Licensee
Unique Homes LLC
4922 Newton Avenue North
Minneapolis, MN 55430

RE: Project Number(s) SL35310015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for

reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35310	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37311015 On January 3, 2023, through January 5, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	0 250		

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0 250	Continued From page 2 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 3, 2023, at 10:45 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations	0 250		

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0 250	Continued From page 3 and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I	0 250		

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0 250	Continued From page 4 understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements	0 250		

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0 250	Continued From page 5 related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-B on May 31, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) infection control practices; (5) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (6) medication and treatment management;	0 250		

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0 250	Continued From page 6 (7) supervision of unlicensed personnel performing delegated tasks; and (8) quality improvement and quality management activities. Throughout survey on January 3, 2023, and January 4, 2023, RN-A and LALD-B confirmed the licensee provided orientation, skill training and supervision to staff, conducted resident assessments, medication management services and other direct-care services to residents but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued: 0250, 0460, 0470, 0485, 0570, 0580, 0660, 0680, 0700, 0730, 0780, 0790, 0900, 0910, 0930, 0940, 1370, 1380, 1440, 1460, 1500, 1530, 1620, 1640, 1650, 1700, 1710, 1770, and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's	0 460		

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0 460	Continued From page 7 visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week (24/7). This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 3, 2023, at 10:55 a.m., during the entrance conference, registered nurse (RN)-A and licensed assisted living director (LALD)-B stated they did not have a system in place for residents to summon assistance 24/7. On January 4, 2023, at 8:50 a.m., resident (R1)	0 460		

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0 460	Continued From page 8 stated they did not have, nor were offered, a pendant or call light they could use to summon assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

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0 470	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 3, 2023, at 11:25 a.m., licensed assisted living director (LALD)-B provided one staffing plan, undated, and indicated registered nurse (RN)-A had prepared it. The staffing plan failed to include: - staffing metrics used to determine appropriate staffing levels; and - dated evaluations, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On January 3, 2023, at 10:45 a.m., during the entrance conference, LALD-B stated they had a staffing plan and thought it was updated last month. LALD-B stated they currently required one staff member per shift. RN-A stated she was unsure if they had a staffing plan. No further information was provided.	0 470		

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0 470	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food menus were prepared and made available for residents no less than one week in advance. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485		

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0 485	Continued From page 11	0 485		

a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On January 3, 2023, at 10:19 a.m., the surveyor observed a menu on a bulletin board in the office space of the facility basement. The menu was completed, undated, and labeled "Week 1."

During the facility tour on January 3, 2023, at 11:35 a.m., unlicensed personnel (ULP)-C and program manager (PM)-F stated usually the monthly menu was posted in the kitchen, but neither were able to locate one. Program director (PD)-E provided a menu, the same menu observed on the bulletin board in the office space of the facility basement. PD-E stated the menu had not been posted because it wasn't finished.

On January 4, 2023, at 8:50 a.m., resident (R1) stated the facility had not posted a menu in a while. R1 stated the facility had never provided a menu to her directly.

The licensee's Food Service and Menu Planning policy dated August 1, 2021, indicated, "Menus will be prepared at least one week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning."

No further information provided

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2023, at 10:19 a.m., the license was observed posted in the office space located in the basement. During a facility tour on January 3, 2023, at 11:35 a.m., the surveyor observed the main entrance and commons area which lacked the required license posting. On January 3, 2023, at 11:35 a.m., program director (PD)-E stated the license was only posted downstairs in the office space. Registered nurse (RN)-A stated it should probably have been posted upstairs at the main entrance.	0 570		

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	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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0 570	Continued From page 13 On January 4, 2023, at 1:47 p.m., RN-A stated she understood the license needed to be posted at the front entrance of the building. RN-A took the license down off the basement office space wall, brought it upstairs, and displayed it in the commons area near the front entrance. The licensee's Assisted Living License and Posting policy dated August 1, 2021, indicated, "The original current license shall be displayed at the main entrance." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain	0 580		

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0 580	Continued From page 14 documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 3, 2023, at 10:15 a.m., the surveyor requested the licensee's quality management plan and meeting minutes. Licensed assisted living director (LALD)-B stated they had quality management meetings but was unsure if they had documentation to provide. LALD-B stated there might be copies of their quality management agendas. The surveyor requested the agendas and notes/minutes from the meetings. On January 4, 2023, at 10:00 a.m., the surveyor requested the past 12 months of quality management documentation from registered nurse (RN)-A who stated LALD-B would be providing them. On January 4, 2023, at 1:27 p.m., the surveyor requested the past 12 months of quality management documentation from RN-A who stated program manager (PM)-F would provide them.	0 580		

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0 580	Continued From page 15 On January 4, 2023, at 1:40 p.m., the surveyor requested the past 12 months of quality management documentation from PM-F who stated she might have some agendas but there were no notes/minutes. On January 4, 2023, at 3:43 p.m., the surveyor emailed LALD-B and requested the past 12 months of quality management documentation. The licensee's Quality Management Project policy, dated August 1, 2021, indicated, "Document the quality management process; keep all related documents on file for at least two years," further, "The quality management documentation should be made available, upon request, to MDH [Minnesota Department of Health] surveyors and OHFC [Office of Health Facility Complaints] investigators." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660		

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0 660	Continued From page 16 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a current tuberculosis (TB) screening test performed within the past 90 days prior to hire for two of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-D). Further, the licensee failed to provide TB training upon hire for one of three employees (ULP-C) based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A was hired on November 15, 2022. ULP-C was hired on April 15, 2022. ULP-D was hired on January 13, 2022. TB SCREENING TESTING RN-A's employee record included a negative QuantiFERON-TB Gold Plus test result, dated	0 660		

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0 660	Continued From page 17 May 22, 2022. The test result exceeded the requirement to be completed within 90 days prior to hire. ULP-D's employee record included a negative QuantiFERON-TB Gold Plus test result, dated June 5, 2019. The test result exceeded the requirement to be completed within 90 days prior to hire. TB TRAINING UPON HIRE ULP-C's employee record included an OSHA and Infection Control Educare (online training program) training certificate dated August 10, 2022, which contained TB training. The TB training was not completed upon hire as required. On January 3, 2023, at 1:25 p.m., RN-A was shown TB test result for both RN-A and ULP-D. RN-A stated she believed a QuantiFERON-TB Gold test was valid for one year. RN-A stated she was aware of the requirements for TB training upon hire for her staff. RN-A stated the previously employed facility nurse failed to ensure it was completed. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.	0 660		

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0 660	Continued From page 18 The licensee's Occupational Exposure to TB/Prevention of Transmission of TB Plan policy, undated, indicated "All employees will receive education regarding TB that is relevant to their particular occupational group, before initial assignment and annually," further, "New Employees/Contractors will produce recent (within 12 months) evidence of a negative PPD or chest x-ray prior to working with PPHC clients." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 19 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. Further, the EP plan was not prominently displayed and available for residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP manual lacked: - emergency procedures and information tailored to the facility; - dates of review; and - was not prominently displayed and available for residents, staff, and visitors. On January 3, 2023, at 11:35 a.m., during the facility tour, the surveyor could not locate the EP plan posted prominently. Both licensed assisted living director (LALD)-B and registered nurse (RN)-A stated the EP plan was kept in the	0 680		

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0 680	Continued From page 20 basement office space. On January 3, 2023, at 1:47 p.m., RN-A stated she was aware the EP plan had many issues and had not been tailored to the facility yet. On January 4, 2023, at 2:04 p.m., LALD-B stated they had just gotten a new EP plan template and were in the process of creating a new EP plan for the licensee. LALD-B stated he only had time to enter some basic facility and resident information. LALD-B stated the EP plan was available to anyone who requested but was not prominently displayed and available. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2022, indicated, "[The licensee's] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: - Risk assessment and planning; - Policies and procedures; - A communication plan; and - Staff training and exercises/drills." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss,	0 700		

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0 700	Continued From page 21 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure for all residents at the licensee's facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency preparedness (EP) plan contained resident protected information for all three residents at the facility. The plan contained face sheets for each resident which included, but was not limited to, resident's: name, date of birth, social security number, insurance information, primary doctor, and diagnosis. On January 4, 2023, at 2:04 p.m., licensed assisted living director (LALD)-B stated the EP plan was available to anyone who asked for it. LALD-B stated he did have resident protected	0 700		

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0 700	Continued From page 22 information in the EP plan as he thought it was required to be there. LALD-B stated he is in the process of reworking the EP plan using a new EP plan template and would address the issue by having the resident protected information separated from the main EP plan and only available to staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 23 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all services provided for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 730		

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0 730	Continued From page 24 R1 R1's service agreement dated November 11, 2022, indicated R1 received services for meal preparation, medication management, housekeeping, and mental health management. R1's service log for November and December 2022, and January 2023, lacked documentation for most services provided on the following dates: - November 1 through 30, 2022; - December 1 through 31, 2022; and - January 1, 2023. R2 R2's service agreement dated November 11, 2022, indicated R2 received services for meal preparation, medication management, laundry, housekeeping, and mental health management. R2's service log for November and December 2022, and January 2023, lacked documentation for most services provided on the following dates: - November 1 through 30, 2022; - December 1 through 31, 2022; and - January 1 through 3, 2023. R3 R3's record indicated R3 received services for meal preparation, laundry, housekeeping, activities of daily living (ADLs), and mental health management. R3 service log for November and December 2022, and January 2023, lacked documentation for most services provided on the following dates: - November 1 through 30, 2022; - December 1 through 31, 2022; and - January 1 through 3, 2023. On January 4, 2023, at 1:45 p.m., registered	0 730		

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0 730	Continued From page 25 nurse (RN)-A stated she had been aware of the lack of service documentation in the service log books and was disappointed with what she saw. RN-A stated staff should document for every service provided whether it was provided or not. RN-A stated she had noticed it was a problem and planned to include it with her January education. The licensee's Resident Record - Documentation policy dated August 1, 2021, indicated: "- All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation; - For medications administered or treatments and/or therapies administered, documentation in a resident's chart must include the date and time of the administration; and - When medications, services, treatments, or therapies or not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 26 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms 2nd floor and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 780		

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	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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0 780	Continued From page 27 The findings include: On January 5,2023, between 12:30pm and 1:00pm, survey staff toured the facility with ULP-C. During the facility tour, survey staff observed the smoke alarms are not interconnected with each other and there was no alarm in the 2nd floor level. On January 5,2023, between 12:30pm and 1:00pm, survey staff toured the facility with ULP-C. During the facility tour, survey staff observed there was no Carbon monoxide alarm in lower level bedroom. ULP-C verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 5, 2023, from approximately 12:30pm to 1:00pm, survey staff toured the facility with ULP-C. During the facility tour, survey staff observed the fire extinguisher was not a 2A-10BC model and had not be annually inspected.. ULP-C verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written	0 900		

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0 900	Continued From page 29 contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written and signed assisted living contract with the required content for one of two residents (R1).	0 900		

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0 900	Continued From page 30 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on May 1, 2020. R1's record included a contract dated November 11, 2022. On January 4, 2023, at 11:00 a.m., registered nurse (RN)-A stated the contract for R1 dated November 11, 2022, was the current contract and acknowledged it had been signed by licensed assisted living director (LALD)-B but was not signed by R1. On January 4, 2023, at 2:04 p.m., LALD-B stated he updated contracts for residents based on a survey they had at another one of their facilities. LALD-B acknowledged R1's new contract dated November 11, 2022, had not been signed by R1 and was the current contract. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated, "When a prospective resident decides to move into the facility, an Assisted Living contract is signed and received by the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 910	Continued From page 31	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract to include the required licensing HFID number (licensee's identification number) for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on May 1, 2020. R1's contract dated November 11, 2022, lacked the required licensee health facility identification	0 910		

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0 910	Continued From page 32 (HFID) number. On January 4, 2023, at 11:00 a.m., registered nurse (RN)-A stated R1's contract did not include the required HFID number. On January 4, 2023, at 2:04 p.m., licensed assisted living director (LALD)-B stated all three residents had the new contracts and would be missing the HFID number. The licensee's assisted living license resource manual, undated, indicated the summary and information cover sheet should include, "Legal Name and License Number of the Building." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of	0 930		

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0 930	Continued From page 33 Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract to include required complaint resolution information for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on May 1, 2020. R1's record included a contract dated November 11, 2022. R1's contract lacked the following content: -description of the assisted living facility's complaint resolution process, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. On January 4, 2023, at 11:00 a.m., registered nurse (RN)-A stated all three residents had the same new contract.	0 930		

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0 930	Continued From page 34 On January 4, 2023, at 2:04 p.m., licensed assisted living director (LALD)-B stated all three residents had the new contracts with the same content. The licensee's Assisted Living License Resource Manual, undated, indicated the contract should include, "Complaint Procedure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover	0 940		

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0 940	Continued From page 35 the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on May 1, 2020. R1's record included a contract dated November 11, 2022. R1's contract lacked the following content: -the contact information to obtain long-term care consulting services under section 256B.0911.	0 940		

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0 940	Continued From page 36 On January 4, 2023, at 11:00 a.m., registered nurse (RN)-A stated all three residents had the new contracts and were the same. On January 4, 2023, at 2:04 p.m., licensed assisted living director (LALD)-B stated all three residents had the new contracts and the content was the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment	01370		

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01370	Continued From page 37 reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required competency training was completed for two of two unlicensed employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on April 15, 2022, and was observed providing direct care services to	01370		

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01370	Continued From page 38 residents on January 3 and 4, 2023. ULP-C's employee record lacked the following documentation of required competency training to be completed by a registered nurse (RN): -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired on January 13, 2020, and provided direct care services to residents.	01370		

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01370	Continued From page 39 ULP-D's employee record included a Care Skills Assessment form, dated June 21, 2022, but lacked the following documentation of required competency training completed by a RN: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On January 4, 2023, at 11:44 a.m., ULP-C was unable to identify which competencies she had completed. ULP-C stated she did some online training with registered nurse (RN)-G who was the former RN for the facility.	01370		

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01370	Continued From page 40 On January 4, 2023, at 1:27 p.m., RN-A stated she was aware of the missing competency training documentation in ULP-C and ULP-D's employee records. RN-A stated she did not know if competency training had been completed with any of the current ULPs. RN-A provided new training competency forms she would use going forward for ULP competency training. The licensee's Competency Training Evaluation policy dated August 1, 2023, indicated: "4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN; 5. Training and competency evaluations for all ULP's will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving	01370		

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01370	Continued From page 41 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	01380		

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01380	Continued From page 42 by: Based on observation, interview, and record review, the licensee failed to ensure required competency training was completed for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on April 15, 2022, and was observed providing direct care services to residents on January 3 and 4, 2023. ULP-C's employee record lacked the following documentation of required competency training to be completed by a registered nurse (RN): -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. ULP-D	01380		

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01380	Continued From page 43 ULP-D was hired on January 13, 2020, and provided direct care services to residents. ULP-D's employee record included a Care Skills Assessment form dated June 21, 2022, but lacked the following documentation of required competency training completed by a RN: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On January 4, 2023, at 11:44 a.m., ULP-C was unable to identify which competencies she had completed. ULP-C stated she did some online training with registered nurse (RN)-G who was the former RN for the facility. On January 4, 2023, at 1:27 p.m., RN-A stated she was aware of the missing competency training documentation in ULP-C and ULP-D's employee records. RN-A stated she did not know if competency training had been completed with any of the current ULPs. RN-A provided new training competency forms she would use going forward for ULP competency training. The licensee's Competency Training Evaluation policy dated August 1, 2023, indicated: "6. In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380		

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01380	Continued From page 44 a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 45 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for two of two unlicensed staff (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on April 15, 2022, and was observed providing direct care services to residents on January 3 and 4, 2023. ULP-C's employee record included a RN Performance Evaluation - 30 days form dated May 30, 2022, which lacked tasks which required a 30-day RN supervision. ULP-D ULP-D was hired on January 13, 2020, and	01440		

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01440	Continued From page 46 provided direct care services to residents. ULP-D's employee record included a RN Performance Evaluation - 30 days form dated March 12, 2022, which lacked tasks which required a 30-day RN supervision. On January 3, 2023, at 1:25 p.m., RN-A stated ULP-C's record did not include any 30-day RN supervision documentation. RN-A stated ULP-C should have had a 30-day RN supervision after competency training. On January 4, 2023, at 1:27 p.m., RN-A stated she was aware of the missing 30-day RN supervision for both ULP-C and ULP-D. RN-A stated all ULP files contained incomplete 30-day RN supervisions. RN-A provided new training forms and stated she would be using those going forward for ULP 30-day RN supervisions. The license's Competency Training Evaluations policy, dated August 1, 2021, indicated, "A copy of all education, training, and competency testing shall be kept in each employee's personnel file." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated	01460		

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01460	Continued From page 47 into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on April 15, 2022, and was observed providing direct care services to residents on January 3 and 4, 2023. ULP-C's employee record lacked documentation of required orientation to include: - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults; - handling of resident complaints, reporting complaints, where to report;	01460		

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01460	Continued From page 48 - review of types of assisted living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; and - orientation to each specific resident and services provided. ULP-D ULP-D was hired on January 13, 2020, and provided direct care services to residents. ULP-D's employee record lacked documentation of required orientation to include: - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults; - handling of resident complaints, reporting complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; and - orientation to each specific resident and services provided. On January 4, 2023, at 11:44 a.m., ULP-C stated she did not get orientated to assisted living facility licensing requirement and regulations. On January 4, 2023, at 1:27 p.m., registered nurse (RN)-A stated she was aware ULP-C and ULP-D's employee records lacked most of the required orientation documentation which included the orientation to assisted living facility licensing requirements and regulations. RN-A stated the nurse prior to her hire should have	01460		

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01460	Continued From page 49 made sure these items were completed. RN-A stated she was not sure if the orientation had been completed by any other ULPs. RN-A showed the surveyor the new orientation forms and organized binders she planned to use for orientation going forward and was in the process of updating them for current employees. The licensee's Orientation of Staff and Supervisors Content policy dated August 1, 2021, indicated an employee's "orientation must include an overview of the appropriate Assisted Living statutes and rules." The policy also indicated: "The orientation must contain the following topics: - An overview of the appropriate Assisted Living statutes and rules; - An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - Handling of emergencies and use of emergency services; - Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01460		

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01460	Continued From page 50 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - A review of the types of assisted living services the employee will be providing and the facility's category of licensure; - The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed; - The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and - The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500		

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01500	Continued From page 51 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500		

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01500	Continued From page 52 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-D). In addition, the licensee failed to include any of the required training topics for the annual training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on January 13, 2020, and provided direct care services to residents. ULP-D's employee record lacked documentation of annual training which would have been required in January 2021, and 2022. On January 4, 2023, at 1:27 p.m., registered nurse (RN)-A stated she was aware ULP-D's employee records lacked documentation of annual training. RN-A stated the nurse prior to her hire should have made sure the annual	01500		

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01500	Continued From page 53 trainings were completed. RN-A showed the new annual training forms and organized binders she planned to use for orientation going forward and was in the process of updating them for current employees. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated, "All staff that perform direct care services at [the licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01530		

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01530	Continued From page 54 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 160 hours of hire for two of three employees (unlicensed personnel (ULP)-C, ULP-D). Further, ULP-D's record lacked the required two (2) hours of annual dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on April 15, 2022, and was observed providing direct care services to residents on January 3 and 4, 2023. ULP-C's employee record lacked documentation of completed dementia care training to include eight hours within 160 hours of date of hire. ULP-C's record included 3.5 hours of documented dementia care training.	01530		

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	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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01530	Continued From page 55 ULP-D ULP-D was hired on January 13, 2020, and provided direct care services to residents. ULP-D's employee record lacked documentation of completed dementia care training to include eight hours within 160 hours of being hired. ULP-D's record included 3.5 hours of documented dementia care training. Further, ULP-D's employee record lacked the required two hours of annual dementia care training since date of hire. On January 4, 2023, at 11:44 a.m., ULP-C stated she had dementia training when she was hired but was unsure how many hours. On January 4, 2023, at 1:27 p.m., registered nurse (RN)-A stated she was aware of the missing dementia care training. RN-A stated the 3.5 hours of training did not meet the dementia care training requirements for ULP-C and ULP-D. RN-A also acknowledged ULP-D's employee record lacked any required annual dementia care training. The licensee's Dementia Training policy, dated August 1, 2021, indicated, "Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date." Further, "All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 56	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 90 calendar days from the last assessment date for two of two residents (R1, R2). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 57 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 1, 2020. R1's record contained one 90 day RN nursing assessment, dated December 1, 2022, but lacked any other RN nursing assessments since R1's admission. R2 R2 was admitted on August 7, 2020. R1's record contained one 90 day RN nursing assessment, dated December 6, 2022, but lacked any other RN nursing assessments since R2's admission. On January 4, 2023, at 11:00 a.m., RN-A stated all three residents records were missing nursing assessments. RN-A stated she had completed 90-day RN nursing assessments as soon as she was hired, but none were completed prior. The licensee's Assessment, Reviews and Monitoring policy, dated August 1, 2021, indicated, " Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 58 calendar days from the last date of the assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a service plan in place	01640		

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01640	Continued From page 59 documenting agreement on the services to be provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 5, 2020. R1's service plan dated November 11, 2022, included: assistance with mental health management, behavioral management, medication management, dressing, laundry, housekeeping, continence assistance, food preparation, socialization, and reassessments. R1's record lacked a service plan prior to the current service plan. R2 R2 was admitted on August 7, 2020. R2's service plan dated November 11, 2022, included: assistance with mental health management, behavioral management, medication management, dressing, laundry, housekeeping, continence assistance, food preparation, socialization, and reassessments. R2's record lacked a service plan prior to the current service plan.	01640		

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01640	Continued From page 60 During the entrance conference on January 3, 2023, at 10:45 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B both stated the RN and LALD were responsible for creating service plans based on admission assessments and updating as needed. On January 4, 2023, at 8:50 a.m., R1 stated she had been getting services since she was admitted to the facility. On January 4, 2023, at 11:00 a.m., RN-A stated the service plans for R1 and R2 were done on November 11, 2022, just prior to her being hired. RN-A stated she was not the nurse when they were admitted and could not confirm if others were completed. The licensee's Service Plan policy dated August 1, 2021, indicated, "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 61 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01650		

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01650	Continued From page 62 The findings include: R1 R1 was admitted on May 1, 2020. R1's service plan dated November 11, 2022, included: assistance with mental health management, behavioral management, medication management, dressing, laundry, housekeeping, continence assistance, food preparation, socialization, and reassessments. On January 4, 2023, at 8:40 a.m., unlicensed personnel (ULP)-C provided medication administration to R1. R1's service plan dated November 11, 2022, lacked the following content: -the fees for services; and -the frequency of each service, according to the resident's current assessment and resident preferences. On January 4, 2023, at 8:50 a.m., R1 stated she had been getting services since she was admitted to the facility. R2 R2 was admitted on August 7, 2020. R2's service plan dated November 11, 2022, included: assistance with mental health management, behavioral management, medication management, dressing, laundry, housekeeping, continence assistance, food preparation, socialization, and reassessments. R2's service plan dated November 11, 2022, lacked the following content: -the fees for services; and	01650		

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01650	Continued From page 63 -the frequency of each service, according to the resident's current assessment and resident preferences. During the entrance conference on January 3, 2023, at 10:45 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B both stated the RN and LALD were responsible for creating service plans and including required content. On January 4, 2023, at 11:00 a.m., RN-A stated the service plans for all residents were missing the same information. The licensee's Service Plan policy dated August 1, 2021, indicated, "Services plans shall include fees for the services indicated in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include	01700		

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01700	Continued From page 64 an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1	01700		

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01700	Continued From page 65 R1 was admitted on May 1, 2020, and received medication management services. R1's record included a Medication Assessment form, dated May 4, 2020, which had not been completed prior to providing medication services. Further, the Medication Assessment form lacked evidence the RN conducted a medication management assessment to include: - identification and review of all medications the resident is known to be taking; - review and identification must include indication, side effects, contraindications, allergies, adverse reactions and actions to address these issues; and - provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On January 4, 2023, at 8:50 a.m., R1 stated she had been receiving assistance with medications since her admission to the facility. R2 R2 was admitted on August 7, 2020, and received medication management services. R2 records lacked a completed RN medication management assessment prior to providing medication management services. R2's record included an Individualized Medication Management Plan dated November 11, 2022. R3 R3 was admitted on January 1, 2020, and received medication management services. R3's records lacked a completed RN medication management assessment prior to providing	01700		

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01700	Continued From page 66 medication management services. On January 3, 2023, at 10:45 a.m., RN-A and licensed assisted living director (LALD)-B both stated medication management plans were to be completed by the RN prior to admission, with every 90-day nursing assessment and as needed. On January 4, 2023, at 11:00 a.m., RN-A stated to her knowledge R1, R2, and R3 had been receiving medication management services since their admission dates. RN-A stated all residents should have a medication management plan, but current records did not. The licensee's Medication Management Individualized Plan dated August 1, 2021, indicated" "1. [The licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional	01700		

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01700	Continued From page 67 when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions 2. The medication management record will be current and updated when there are any changes. 3. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a	01710		

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01710	Continued From page 68	01710		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1 was admitted on May 1, 2020. R1's service agreement, dated November 11, 2022, indicated R1 received medication management services.

On January 4, 2023, at 8:40 a.m., R1 was observed receiving medication administration by unlicensed personnel (ULP)-C.

R1's record included a Medication Assessment form dated May 4, 2020. R1's record lacked any further medication reassessments required annually.

R2
R2 was admitted on August 7, 2020. R2's records indicated R2 received medication management services.

R2's record included an Individualized Medication Management Plan dated November 11, 2022. R2's record lacked any further medication reassessments required annually.

R3
R3 was admitted on January 2, 2020. R2's record indicated R2 received medication management services.

R3's records lacked a completed RN medication

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 69 management assessment. On January 4, 2023, at 8:50 a.m., R1 stated she had been receiving assistance with medications since her admission to the facility. On January 3, 2023, at 10:45 a.m., RN-A and licensed assisted living director (LALD)-B both stated medication management plans should be reviewed and updated annually. On January 4, 2023, at 11:00 a.m., RN-A stated to her knowledge R1, R2, and R3 had been receiving medication management services since their admission dates. RN-A stated all three residents were missing required annual reviews of medication management plans. The licensee's Medication Management Individualized Plan dated August 1, 2021, indicated "1. [The licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35310	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE HOMES LLC	4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 70 f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions 2. The medication management record will be current and updated when there are any changes. 3. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of a medication setup was accurate for one of two residents (R1). This practice resulted in a level two violation (a	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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01770	Continued From page 71 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 4, 2022, at 8:40 a.m., unlicensed personnel (ULP)-C administered medication to R1. R1's pillbox did not contain the clonazepam as documented on the MAR. ULP-C stated clonazepam was a controlled substance and was kept locked in the controlled substances lock box. ULP-C took one clonazepam tablet from the punch card, kept in the controlled substance lock box, to administer to R1. ULP-C stated the clonazepam was never setup in the pillbox. R1's service plan dated November 11, 2022, indicated R1 received services for medication management. R1's medication setup documentation dated January 1 through 8, 2023, indicated registered nurse (RN)-A had setup R1's medications. The medication setup documentation indicated the following controlled medication was setup in the pillbox: - clonazepam 0.5 milligram (mg) tablet; take one tablet by mouth twice daily. During the entrance conference on January 4, 2022, at 10:45 a.m., RN-A stated she did weekly setups for medications in pillboxes for all three residents. RN-A stated only the RN was allowed to setup the medications.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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UNIQUE HOMES LLC	4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430

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01770	Continued From page 72 On January 5, 2023, at 3:19 p.m., RN-A stated she did weekly medication setups in pillboxes. RN-A stated she set up scheduled medications except for controlled substances which were removed from the controlled substances lock box at the time of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the two facility entrances to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35310	A. BUILDING: _____ B. WING _____	01/06/2023

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03090	Continued From page 73 affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2023, at 9:45 a.m., the surveyor entered the facility and observed the main entrance and interior commons area lacked the required signage for electronic monitoring notice to visitors. The main entrance had a red sign which indicated, "Warning Security Camera in Use." During the facility tour on January 3, 2023, at 11:35 a.m., registered nurse (RN)-A stated they thought the sign they had on the front door was enough. On January 4, 2023, at 2:45 p.m., the surveyor observed the front and side entrances of the facility lacked the required signage for electronic monitoring notice to visitors. The licensee's undated Electronic Monitoring Preparedness Checklist policy indicated, "Post signage at each facility entrance accessible to visitors. The signage must state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *01/03/23*
Time: 13:00:49
Report: 1023231001

Food and Beverage Establishment Inspection Report

Location:
Unique Homes Llc
4922 Newton Avenue North
Minneapolis, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038233
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632224909
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE STAFF ARE EMPLOYEES OF FACILITY.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FOOD SERVICE FOR HIGHLY SUSCEPTIBLE POPULATIONS

Type: Full
Date: *01/03/23*
Time: 13:00:49
Report: 1023231001
Unique Homes Llc

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023231001 of 01/03/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
ETIMA KOLLIE
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us